

**Developmental Disabilities Division**


**Case management training  
for new case managers**


**March 2009**

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**Tools needed for training:**  
(available on the Division's website)

- ✓ Plan of care
- ✓ IPC Instructions
- ✓ Provider Manual and Updates
- ✓ Sample Objective and Schedule
- ✓ Preapproval Form
- ✓ Rights, Restrictions, and Responsibilities Tool



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**Training Agenda**

- Applying for waiver
- Targeted Case Management
- Team Meetings
- Transitions
- Person-center planning
- Plan of Care components
- IBA, Pre-Approval, modifications, ECC
- Staffing Ratios
- Intervention
- Monitoring Implementation of plan
- Upcoming Changes
- Resources and future trainings

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### ***Applying for the Waiver***

**Call the local Area Resource Specialist (ARS)** 

- The ARS will meet with applicant to explain: (from Resource Guide)
  - ✓ Review the application
  - ✓ Application process
  - ✓ Waiver application checklist

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### ***Applying for the Waiver***

- Eligibility/Assessments
- Choosing a provider
- Description of services
- Roles and responsibilities

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### ***Targeted Case Management Purpose***

- Help applicant gather needed documentation and testing to determine waiver eligibility
- Assist applicant to access other services:
  - ✓ Medicaid services
  - ✓ Employed Individuals with Disabilities
  - ✓ State Respite
  - ✓ Services through Independent Living Organization, Senior Citizen Centers, Mental Health Centers, Advocacy Groups, or others

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**Process for TCM**

- Case Manager signs the ISC Selection Form
- Case Manager should complete the TCM form **AT THE SAME TIME** and send both to the Area Resource Specialist
- If applicant is already Medicaid eligible, a PA is generated and letter sent to Case Manager
- If applicant is not eligible, DDD facilitates a temporary Medicaid ID, then PA letter is generated

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**What is covered under TCM**

- Gathering Information
- Linkage
- Monitoring/Follow-up
- Referral
- Advocacy
- Crisis Intervention

*TCM does not cover direct services such as transportation to appointments*

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**Reimbursement for TCM**

- 15 minute units for a maximum of 120 units in a plan year (\$960)
- Forms are on DDD website along with a link to EqualityCare, explaining the electronic billing for TCM
- Case Managers must complete Service Log
  - ✓ Do not send to the Division
  - ✓ Keep in records

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### **Targeted Case Management Plan**

- TCM plan is similar to a Plan of Care – effective for almost a year
- Start date – the date the case manager is selected
- End date – the last day of the previous month
- If the case manager changes, the end date stays the same

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### **Waiting Lists and TCM**

- Follow up and Referral are very important for individuals waiting for services
- Case Managers should check in regularly and see if needs have changed, if contacts with other programs have been made
- The Waiver Manager can tell you status of the applicant on the waiting list
- You **MUST** fill out a new TCM form and get a new PA number

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## Questions?




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### ***Team Meetings***

#### **Why are team meetings are held?**

- Identify needs
- Team process
- Know what participant wants
- Knowledge/better serve participant
- Develop/review plan of care

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### ***Team Meetings***

#### **When are team meetings held?**

- Annual and 6 month reviews
- Any team member request
- Transitions
- Special circumstances
- DDD request
- \* Remember the 30 day notice to the Division ARS!

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### ***Team Meetings***

#### **Who attends team meetings?**

- Participant
- Family/natural supports/guardians
- Direct support staff
- Friends, co-workers, employers
- Participant/guardian invites
- Affiliated agencies i.e. school, DVR, therapists, medical staff

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### **Team Meetings**

#### **Transitions**

- *Why?* Information exchange
  - Timely / efficient
  - Ensures smooth transition
  - Communication
  - ID roles & responsibilities
  - Assurances of needed units

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### **Team Meetings/Transitions**

- *When?* \*Two week notice\*
  - Change of case manager
  - Change of habilitation service
  - Physical move
  - Change in waiver habilitation providers
  - Change in waiver (ex: kid to adult)
- *Who?*
  - Participant/guardian/family
  - Whom ever is involved in transition

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### **Importance of the Plan of Care**

#### **Why do we have to develop a plan of care?**

- Because CMS tells us to! *(It is how the state receives federal funds for the waivers.)*
- The plan of care identifies the waiver services, as well as other services and supports, which a person needs in order to live successfully in the community and, therefore, avoid institutionalization.

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### ***Importance of the Plan of Care***

#### **Develop the plan**

- ✓ Identify participant's needs, goals and preferences

#### **Develop strategies**

- ✓ Address the needs, goals and preferences.

#### **Participation**

- ✓ Enable and support the participant or guardian to fully engage in and direct the planning process to the extent he/she chooses.

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### ***Importance of the Plan of Care***

#### ***What is person-centered planning?***

- Allowing participants to describe where and with whom they want to live, whom they want to socialize with, how they would like to spend their time, what jobs they want to have and other aspects of their daily lives...then helping them to achieve these things!

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### ***What you hear depends on what you are listening for!***




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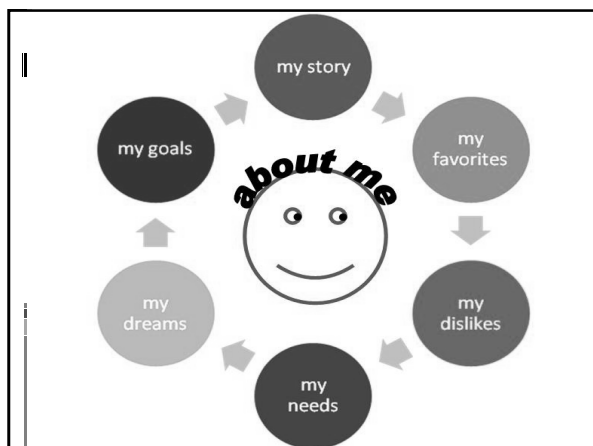
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### **PERSON CENTERED PLANNING ISN'T NEW AND IT ISN'T HARD**

- **It's Listening** to where a person wants to live and work, spend each day, to whom (s)he wants to spend time, & his/her future hopes and dreams
- **It's Supporting** a person in his/her "choices", preferences, joining (s)he with the same focus, strengthening personal relationships, and helping (s)he plan, act, and learn.
- The Division uses the **"About Me"** section to and encourage person-centered planning.

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### **More "About Me"**

- Completed before team meeting, then reviewed with team at meeting
- Used to determine proper services, schedules, objectives, and supports
- It should record the participant's past progress on objectives and important changes happening in his/her life.
- Waiver Specialists use this section to check plan for supports and services reflective of the participant's wants, needs, and desires.

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**Who is the audience for the IPC?****Providers/Provider Staff/Participants/Families**

- Use complete statements, which accurately reflect the participant's and team's responses
- Use First-Person language
- Make sure the plan is easily understood
- Give clear instruction and descriptions
  - ✓ Staff should be able to read the document and know the unique things about the participant, receive clear instruction on how to work with the person, keep them safe, and follow protocols as included.

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**Rights and Restrictions****Discussing Rights**

Use the Team Meeting Checklist and the Rights, Restrictions, and Responsibilities Tool as a guide

**Discussion should include:**

- Who has rights?
- What are rights?
- How may rights be limited? Is the participant under 18 years of age?
- Do participants have responsibilities?

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**Rights and Restrictions****Deciding on Rights Restrictions**

- Specific rights listed in the Instructions for Developing a Plan of Care may be modified
- If restraints used, then it must be listed as a restriction of rights

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## Deciding on Rights Restrictions

*continued*

- Differences between the rights of children and adults
- Age of the child
- Rights restrictions must be documented for participants 18 and over, regardless of waiver.

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## ***Rights and Restrictions***

### **Recording Rights Restrictions in Plan of Care**

- All restrictions shall be identified on the Rights Restriction section of the Plan of Care (*refer to the Instructions for Developing the IPC for help!*)
- All restrictions shall identify the following:
  - Why the restriction is imposed
  - How it is imposed
  - A Plan to restore rights
  - A date to review restrictions
  - A signature and date from the appropriate person

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# Questions?




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### ***Plan of Care Development***

- Developed by the participant/guardian and the team
- Remember the 20 calendar day rule- new case managers should turn it in 30 days ahead of start date

#### **Planning within a Budget**

- See the July 7, 2008 Memorandums
  - ✓ Funding for one year
  - ✓ Prorated if plan is less than 12 months

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### ***Plan of Care Development***

#### **Eligibility**

- Adult/Child DD Level of Care form – “LT-MR-104”
- ABI Level of Care Form – “LT-MR-105”

#### **Individualized**

- Reviewed by the Division annually
- Developed during the team meeting, however;
- Certain portions of the plan may be developed prior to the team meeting.

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### ***Plan of Care Development***

#### **Choosing Services**

- ✓ Participant driven
- ✓ Non-Waiver Services
- ✓ Waiver Services
- ✓ Notice of Choice Form
- ✓ Signature dates

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### ***Plan of Care Development***

#### **Medical Information**

- Complete picture of participant's health and medical needs.
- No blanks
- PRN Medications

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### ***Plan of Care Development***

#### **Identifying Supports**

- Each participant's Functional Limitations must be addressed
- Protocols may be required for very specific instructions

#### **Describing Supervision**

- Least restrictive and most appropriate
- Psychological Evaluation
- ICAP Service Score

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### ***Objectives***

#### **SMART**

- **S**pecific
- **M**easurable
- **A**ttainable
- **R**elevant
- **T**ime Specific and **T**rackable

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### **Objectives**

#### ▪ Objectives are required for all habilitation services:

- Residential Habilitation
- Special Family Habilitation Home
- Day Habilitation/PreVocational
- In Home Support/Res Hab Training
- Supported Employment, Community Integrated Employment
- Supported Living

*An objective must be taught for each day or unit billed*




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### **Objectives**

#### Developing the training objective:

- Start with the area of interest or need for training (*remember to be person-centered!*)
- Discuss what could be achieved the next year.
- Develop a step by step process for the training.

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### **Objectives**

#### Remember to write a SMART objective

- My objective is...
- How will this objective help me?

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## **Objectives**

### **Make it Measurable:**

- What data is helpful to keep track of?
- How will data be used?
- How will the data be tracked:
  - ✓ Schedule, or
  - ✓ Task analysis sheet?

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## **Objectives**

- Fill out the Universal Objective Page
- Track the information
- Revise the objective as often as needed

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## **Objectives**



**Celebrate  
Success!!!**

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## **Schedules**

- Schedules are the tools needed for billing documentation and proof that services were provided.
- Schedules must be submitted for all Habilitation, Respite, Personal Care, and Homemaking Services.

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## **Schedules**

Schedules should be developed using comprehensive information about the participant, including:

- The "About Me" section
- The "Supports" section
- The "Positive Behavior Support Plan"
- And any other pertinent information discussed at the plan of care meetings.




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## **Schedules**

### **All schedules must include:**

- Participant name, Provider name
- Location of service
- Plan date
- Number of units to be used per day/week/month
- Name of service or service code
- Date of service
- Actual, specific, personalized activities of the participant
- Notes/comments section
- Times in and out of service
  - Must be documented using either AM/PM or military
  - Provider signature on each page

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## Schedules

- All schedules for the Adult and ABI Waivers require supervision levels to be listed.
- Level of supervision needed, as specified in the “Supports” section of the IPC.
- Staffing ratios should not be included unless the person requires 1:1 or higher.
- Schedules may be a separate document from a task analysis sheet.

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## Schedules

- If schedules are more than one page long, the same header information and signatures are required on each page.
- Schedules can be created in any format which includes all of the required information.
- Sample schedules are posted on the Division website at:  
<http://wdh.state.wy.us/ddd/ddd/ipcforms.html>



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# Questions?



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### **Positive Behavior Support Plans**

#### **Positive Behavior Supports Plan (PBSP) –**

- A written plan based on a functional assessment of behaviors that negatively impact one's ability to acquire, retain, and or improve the self-help, socialization, and adaptive skills necessary to reside successfully in his/her home & community
- It contains multiple intervention strategies & data collection designed to modify the environment & teach new skills.

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### **Positive Behavior Support Plans**

#### **Please include a PBSP in the plan of care when behaviors are identified as:**

- Needing to be eliminated or changed by the team or psychologist
- Serious health & safety concerns
- Moderate or above on the current ICAP assessment
- Barriers to independence, employment, or community interactions

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### **Positive Behavior Support Plans**

#### **Most Behaviors Serve Two Purposes :**

- Getting /Obtaining
- Avoiding/Escaping

#### **The First Step:**

- ✓ Determine the message or reason for the behavior.

#### **Then Consider:**

- ✓ The function of the challenging behavior?
- ...Use A Functional Behavioral Analysis (FBA)

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## Positive Behavior Support Plans

**Functional Behavioral Analysis** - Information gathered & data recorded relating to the what, when, who and why of the targeted behaviors.

### Gather Information Utilizing:

- Direct Observation
- Interviews with People
- Pertinent History
- Possible Causes of the Behavior
- Evaluation of the Environments




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## Positive Behavior Support Plans

Use the information from the FBA to develop a Positive Behavior Supports Plan (PBSP):

- Describe Behavior
- Predict When & Where
- Identify Possible Reasons
- Develop Strategies of Intervention



Sample PBSP:

<http://wdh.state.wy.us/ddd/ddd/ipcforms.html>

Click on "Sample Positive Behavior Support Plan"

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## Positive Behavior Support Plans

### Resources Available

- DDD Website: <http://sdh.state.wy.us/ddd/index.html>
- Shawn Powell, Licensed Psychologist in Casper
- Mental Health & Substance Abuse Division website: <http://www.health.wyo.gov/mhsa/index.html>
- Community Mental Health Centers
- Children's Mental Health Waiver
- School District Behavioral Health Teams
- UW, Dept. of Psychology, e-mail: [psyc.uw@uwyo.edu](mailto:psyc.uw@uwyo.edu)

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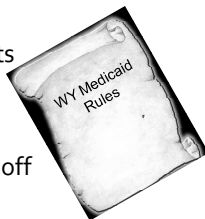
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### **Positive Behavior Support Plans**

#### **Restrictions and Reference to Rule**

- ✓ Chapter 45, Section 29
  - Match Restriction of Rights
  - What is restricted?
  - PRN Protocol
  - Can participant earn time off the restriction?



*Note:* Community restriction cannot exceed 36 hours unless approved by a psychologist for health & safety or therapeutic reasons.

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### **Positive Behavior Support Plans**

#### **Reporting and Tracking Requirements**

- Document each Use of a Restraint
- Notice of Incident if restraint resulted in injury; Chapter 45, Section 30
- Document, Document, Document **DDD**
- Review
- Analysis of Patterns of Use/Trends
- *Note:* The Division shall review the reporting and tracking of restraints during the annual recertification of providers.

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### **Positive Behavior Support Plans**

#### **Restraint Usage and Reference to Rule**

- ✓ Chapter 45, Section 28
  - Include order for the restraint
  - List in Restriction of Rights
  - Least restrictive intervention technique
  - Use only if necessary

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### **Positive Behavior Support Plans**

#### **Revising the PBSP as Needed**

- Review at least quarterly for effectiveness
- If plan is not working, gather team and review -don't wait for the 6 month or annual meeting

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### **Positive Behavior Support Plans**

#### **A Few Best Practices Supporting Positive Behavior**

- Respectful Speech
- Set Consistent Behavioral Limits
- No "As Needed" Plans
- Respect the Participants Wishes
- Keep the Supports Plan Positive

*Thanks to Hamilton Co. Board of MR/DD Ohio for list*

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### **Positive Behavior Support Plans**

PBSP are the Key to the Participant's Success




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## Preapproval Form

- Plan Services and Units Within the Budget Provided
- What's the difference between an IBA and the Plan Amount?
- If a plan exceeds the IBA, the request shall go to the Extraordinary Care Committee (ECC)

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[illegible]

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## Preapproval Form

- Include services on the pre-approval that have been identified in the IPC as needed services (please refer to July 7, 2008 Memorandum).
  - Fill out the form completely.
  - Submit the form within 20 days of the start date of the plan.
- (DDD recommends 30 days for new case managers or ECC requests.)*

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### **When to Modify a Plan**

Modifying the plan of care when the participant's needs change:

- Change in services or adding a new service
- Follow the transition checklist for changes in ISC, Residential Habilitation, Day Habilitation services.
- Change in units or rates
- Change in Providers

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### **When to Modify A Plan**

- When a participant moves out of state
- Terminates from the waiver
- When a participant passes away
- Or any other time a plan ends early

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**Pre-approval Form of ABI/DD HCBS Waiver Services – Wyoming Developmental Disabilities Division (DDD)**  
 Check if this is a Modification of an Approved Plan – Modification Effective Date *date*

1. Individually-Budgeted Amount (IBA) \_\_\_\_\_ Participant Medicaid Identification Number \_\_\_\_\_ Participant Social Security Number \_\_\_\_\_

Name List \_\_\_\_\_

Signature of Guardian \_\_\_\_\_ Date of Signature \_\_\_\_\_

Signature of Qualified Mental Retardation Professional (QMPP), ISC \_\_\_\_\_ Date of Signature \_\_\_\_\_

Signature of Participant \_\_\_\_\_ Date of Signature \_\_\_\_\_

ISC Organization \_\_\_\_\_

**Check if this is a Modification** ☒ **modification**

DDD Signature and Date \_\_\_\_\_

Developmental Disabilities Division

Type of Waiver: ☐ ABI ☐ Adult ☐ Children

Revised 3/08

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### ***Modifications***

- See the IPC Instructions, p. 28, for submitting a mod to the plan of care:
- List total number of units for each service that is changing.
- Submit copies of all documentation:
  - Transition Checklist (if required),
  - Signature sheet (p. 16 of the IPC Template)
  - Objectives and schedules that would change
  - Any pages of the IPC that should be modified

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### ***Modifications***

- The ISC should submit the modification to the plan of care seven days before the start date of the mod.
- The ISC is responsible for distributing the pre-approval form and any other relevant IPC documents to service providers prior to the start of the service

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### ***Extraordinary Care Committee***

- The Extraordinary Care Committee Policy, Procedure, and forms are on Division's website
- The case manager submits the completed ECC forms and additional information to the waiver specialist to review and present to ECC.
- The completed case will go to ECC within 10 days of submission. Incomplete cases will not be reviewed.

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### **Staffing Ratios**

- The ICAP score - starting point for suggested supervision level
- Review the Supervision Level Descriptions in the Instructions for Developing the IPC
- Choose the description that best fits, and the plan of care must support this supervision level
- Evaluate the staffing requested with the staffing already being provided to all participants in the home or day site

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### **Example 1**

Participant	Sue	George	Carrie	John	James
Proposed ratio	1:3	1:4	1:3	1:2	1:1
Staff	A	B	A	B	C

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### **Example 2**

Participant	Bill	Fred	Sam	Jim
Proposed ratio	1:3	1:4	1:3	1:4
Staff	A	A	A	A

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Participant	Mary	Sally	Bev	Joan	Beth
Proposed ratio	1:1	1:2	1:3	1:2	1:1
Staff	A	B	C	B	D

Participant	Jeff
Proposed ratio	1:4
Staff	A

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**Intervention**

Participant	Sue	George	Carrie	John	James
Proposed ratio	1:3	1:4	1:3	1:2	1:1
Staff	A	B	A	B	C
Intervention	3 hrs/day due to surgery recovery				
Staff	D – case manager				

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**Intervention**

Participant	Sue	George	Carrie	John	James
Proposed ratio	1:3	1:4	1:3	1:2	1:1
Staff	A	B	A	B	C
Intervention	Any community activity due to pedophile behaviors				
Staff	E – day hab staff who schedules extra time on weekends				




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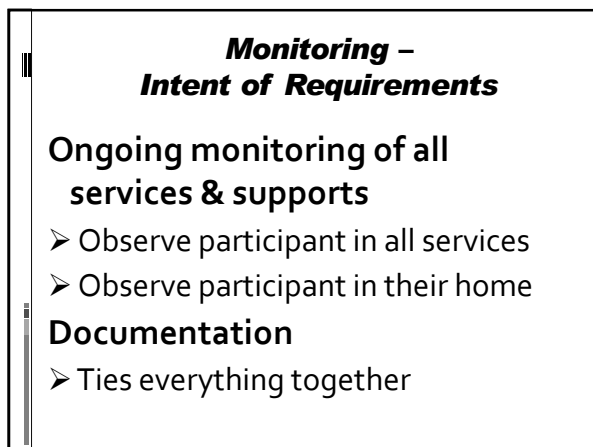
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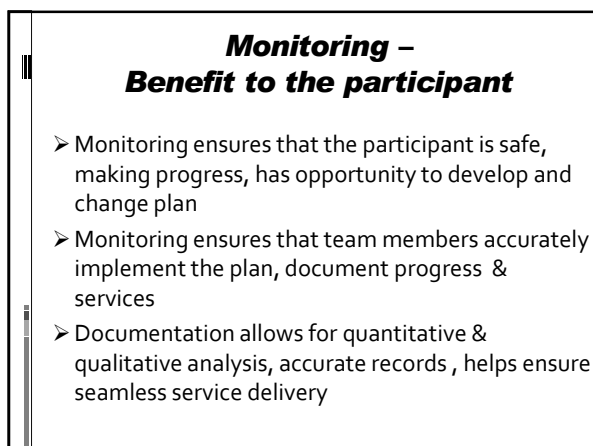
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### **Monitoring – Implementation of the Plan**

Intent of Requirements –  
Ongoing monitoring of all services and supports

➤ Observe participant in all services on plan:

- ✓ Is service meeting the needs intended in IPC?
- ✓ Are all providers carrying out training per IPC?
- ✓ Is the participant safe, satisfied?
- ✓ Is progress being made? If not, why?

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### **Ongoing Monitoring of all Services and Supports**

Observe participant in their home

- Is the participant SAFE?
- Are the participant's needs being met?
- Is intervention of any kind needed?

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### **Benefits to the Participant**

Monitoring ensures the participant:

- is safe
- is making progress
- has opportunity to develop and change the plan

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### ***Benefits to the participant***

Monitoring ensures that staff:



- are accurately implementing the plan
- are accurately documenting progress and services
- are safe, respectful and well-trained

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### ***Documentation***

- Allows for quantitative and qualitative analysis
- Ensures and accurate record for future planning and plan development
- Helps ensure seamless service delivery in case the case manager is not available and/or leaves the team

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### ***Organize Work to Meet Intent of Requirements***

Educate team members

- ✓ Families & guardians have to understand the critical nature of home visits & ongoing communication with them
- ✓ Service providers must appreciate the value of ongoing training & support from the case manager

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### ***Organize Work to Meet Intent of Requirements***

#### **Planning**

- Plan & schedule visits & observations for the entire month
- Prioritize by individual needs
  - ✓ Training objectives
  - ✓ Behavior plan implementation
  - ✓ General staff interaction
  - ✓ Participant & family communication

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### ***Organize Work to Meet Intent of Requirements***

#### **Documentation**

- Ensure all contacts can be documented
- Decide how documentation will consistently occur
- Develop a system
- Communicate the system to back-ups/co-workers

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### ***Helpful Tools***

- ✓ Technology and communication
- ✓ E-mail, computer calendar
- ✓ Efficient voicemail
- ✓ Forms




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### **Forms**



- ✿ Monthly/quarterly
- ✿ Objective tracking
- ✿ Incident reports
- ✿ Restraint & PBSP documentation
- ✿ Home visit checklist
- ✿ Staff training/re-training (for any subject)
- ✿ Participant Specific Training
- ✿ Meetings

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### **Policies and Procedures**

- ✿ Who is served
- ✿ Criteria for & order of Acceptance
- ✿ Who decides Acceptance
- ✿ Appeal & written denial process
- ✿ Referrals
- ✿ Information sharing prior to Acceptance

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### **Review of Monitoring**

#### **Monitoring ensures:**

- Participant is safe, making progress can develop & change plan
- Team members accurately implement plan, document progress & services

#### **Documentation allows for:**

- Qualitative & quantitative analysis
- Accurate records
- Seamless service delivery

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# Questions?




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## **Possible Upcoming Changes**

- ABI and Adult DD waivers are being renewed
- Decisions are dependent on CMS approval
- Case Managers will have their own number
- Conflict of interest policies will be strengthened
- Medication assistance training
- Assessing & mitigating risk
- Back up plan for supported living
- 30 day rule for submitting plans to




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## **RESOURCES**

- ✓ Use the IPC instructions
- ✓ Samples and tools are available on the Division's website
- ✓ Contact Division staff for questions

## **UPCOMING TRAINING**

- ✓ Provider Conference at Parkway Plaza in Casper, April 28 – 30, 2009
- ✓ Regional trainings – schedule on website (May through September 2009)

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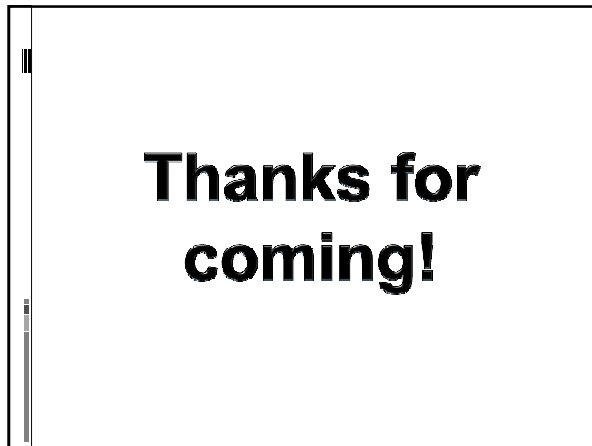
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